

## Registration form Huisartsen Ganzenhoef

**Personal information (from the age of 16 a separate form is required)**

Family members	Surname	First name	Date of birth dd/mm/jjjj	Place of birth	M/F	BSN number	Insurance policy number
1.							
2.							
3.							
4.							
5.							
	Parental authority:	<input type="radio"/> Both parents		<input type="radio"/> Mother		<input type="radio"/> Father	

### Contact information

Street + housenumber			
Postcode + residence			
Phone number 1		Phone number 2	
E-mailaddress			

### Chronische illnesses, medication and exchange of medical data

Do you have any chronic illnesses: <input type="radio"/> YES <input type="radio"/> NO Which illnesses:
Do you use chronic medication: <input type="radio"/> YES <input type="radio"/> NO Which medicine:
Do you agree to the exchange of medical data with GP's on call and or your Pharmacy (through the LSP): <input type="radio"/> YES <input type="radio"/> NO

(new) Pharmacy:		
Previous GP + address		
Date of registration:		Signature:

***I hereby give my permission to send my medical files to Huisartsen Ganzenhoef.***



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